Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS69AGC	A. BUILDING _____ B. WING _____	01/06/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTA CARE HOME	2007 ALTA DRIVE LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of the complaint investigation conducted at your facility on January 6, 2009. This investigation was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the State Board of Health on July 14, 2006. The facility was licensed for 6 total beds. The facility had the following category of classified beds: Category 1 - 6 beds. The facility had the following endorsements: Residential facility which provides care to elderly or disabled persons. Residential facility for persons with mental illness. Residential facility for persons with chronic illness. The census was 5 residents. There was 1 complaint investigated. Complaint # NV00020532 was substantiated without deficiencies. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no deficiencies identified during the survey, No further action is necessary concerning this report. Please retain a copy for	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

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Y 000	Continued From page 1 your records.	Y 000		